

attack; and when the vomiting continues several hours, mucus alone is at last expelled after much effort. The attacks of vomiting are accompanied and followed by intense thirst, retraction of the abdomen, considerable feverishness, and obstinate constipation. Their duration rarely exceeds forty-eight hours; they generally end in eighteen or twenty-four hours. The vomiting is generally accompanied by paleness, loss of flesh, and an appearance similar to that which is observed in cholera. The disorder has generally appeared between the sixth and seventh years of age; it seems to diminish in intensity as time advances, and rarely lasts beyond the twelfth or fourteenth year. There is a remarkable tendency in the disease to repetition; all Dr. Lombard's patients had attacks at intervals of a few weeks during several years; and in one, in whom the paroxysms were always very severe, they lasted until his eighteenth year, when, although he had been for some time free from the disorder, he was seized with incessant vomiting at the commencement and during the first stage of measles. The effect produced on nutrition is remarkable. Most of the patients remained thin, pale, and weak for a number of years; in two girls, who were under Dr. Lombard's observation many years, anæmia was so intense that there was anasarca, not only of the limbs but also of the trunk and face; and yet there was neither diarrhœa, albuminuria, nor cough; nor could the most careful examination detect any organic lesion. One case only proved fatal, in a child aged seven or eight years. At the *post-mortem* examination, the mucous membrane of the stomach was found to be perfectly healthy, without redness, softening, ulceration, or erosion; the intestine, peritoneum, and mesenteric glands were also healthy, as were also the other abdominal organs. In the treatment, Dr. Lombard has tried opiates, bismuth, nux vomica, iced milk or water, ice in pieces, and sinapisms or opiate poultices to the abdomen; but nothing has succeeded so well as total abstinence from drink or medicine. Resisting the entreaties of the patient for drink, he allows nothing to be introduced into the stomach. When the violence of the attack is somewhat assuaged, a teaspoonful of iced water may be given at long intervals, the quantity being increased to a table-spoonful; and when there has been no vomiting for eight or twelve hours, cold chicken-broth or milk may be given by spoonfuls. Great care is required in managing the administration of food; as relapses are likely to occur when it is given too rapidly or in too substantial a form. Enemata are generally required during convalescence; and, if these fail, some mild evacuant, such as castor oil or manna, should be given. With regard to the pathology of the affection, Dr. Lombard says that it is evidently not a gastric inflammation; for such a condition would not disappear so completely in the intervals between the attacks as to allow the patient to regain a certain amount of strength and *embonpoint*; besides which, the total absence of inflammatory lesion in the necropsy of the fatal case contradicts the idea of inflammation. It is not the chronic catarrh of the stomach of MM. Rilliet and Barthez; the milder form of which is characterized by alternations of constipation and diarrhœa; and the more severe by a permanent intolerance of food; nor can the vomitings be considered as purely spasmodic, or the result of a gastric neuralgia.—*Gazette Médicale de Paris*, 18 May, 1861.

33. *Serous Collections in the Female Pelvis*.—M. DEMARQUAY describes (*Gaz. Méd. de Paris*, August 31, 1861) a form of serous collection in the pelvis, connected with non-puerperal recto-peritonitis, or rather with serous pelvi-peritonitis. The true nature of these collections has, he says, been mistaken by other authors. A case in illustration is recorded. A woman came under M. Demarquay's care, on account of the sequelæ of a severe attack of metro-peritonitis. She was found to have a collection of serum in the pelvis. The uterus and bladder were pushed forwards, the rectum backwards; and the functions of these organs were notably impeded. Five hundred and twenty grammes of a yellow fluid were removed by a trocar, and the cavity was injected with a solution of iodine. The patient recovered perfectly. The fluid resembled closely the serum of the blood; and M. Demarquay believes that it was effused into the *cul-de-sac* of the peritoneum between the uterus and rectum, inflammation having extended to this part from the uterus. The diseases with which this serous col-

lection is apt to be confounded are peri-uterine hæmatoecle, and ovarian cyst; but attention to the history of the case, and to the general and local symptoms, will establish the diagnosis.

34. *Obstruction of the Abdominal Aorta by a Clot (detached from the Left Ventricle); Gangrene of the Foot; Death.*—M. BROCA, of the Hôpital de Bicêtre, has communicated to the Société de la Chirurgie, the history of a very interesting case in which this train of events occurred. The patient was a man, æt. 61, who applied to the Bicêtre, on account of a dry gangrene of the little toe of the left foot. He was the subject of a complete paralysis of all four limbs, which had existed with but little alteration since the original attack of palsy, more than thirty years previously. During the latter part of this period, the muscles of the neck had become very weak, and, at the date of his admission, the intercostal muscles had almost entirely ceased to aid the respiratory movements. Sensibility was, as it always had been, perfect. The gangrene was dry, and strictly limited to the little toe. The arteries of *both limbs* were explored carefully from the iliac fossæ to the feet, and neither yielded any sense of pulsation whatever; yet there was no obstructing clot to be felt anywhere in their course. The limb which was the subject of gangrene in its extremity, presented no difference from its more fortunate fellow. Both limbs were of fully normal temperature; from the groins to the knees, they were about equal in this respect; at the level of the *knee*, however, the left limb was the hotter; the left foot, on the contrary, was the colder of the two. A small bed sore which existed on the sacrum rapidly increased in size during the three weeks which succeeded admission to the hospital; diarrhœa also set in, and the patient became extremely weak; still, so far, the gangrene maintained its *dry* character, and had made but inconsiderable progress; but, at this date, there commenced a rapid extension of the sphacelus, which now assumed the thénical type, and rapidly engaged the whole foot, and the inferior fourth of the leg. Simultaneously with this change, the temperature from the knee downward fell sensibly *below* that of the healthy limb. The patient sank, exhausted, on the fourth day from the exacerbation of the gangrenous process.

*Autopsy.*—The muscles and the bones of the palsied limbs were soft and highly fatty. The brain was healthy. The anterior column of the spinal cord—from the level of the fourth ventricle to the lower part of the dorsal region—were *diffuent*, and of a milk-white colour; the posterior columns were also slightly softened, superficially.

The arterial system was almost free from atheromatous disease. The abdominal aorta was obstructed, from its bifurcation for about an inch and a half upwards, by a clot formed of two distinct parts. The larger part (nearest the bifurcation) was of a gray colour, friable, not very adherent to the walls, and was continued into the two common iliacs. Its upper surface presents an abrupt anfractuosity, *as if it had been broken off from somewhere*. The upper portion of the clot was of a red colour, a firmer consistence, and an evidently more recent date of formation, than the lower part. It obstructed the aorta as high as the origin of the last pair of lumbar arteries, when it terminated in a conical point.

In the left ventricle of the heart was formed a clot, entangled among the columnæ carneæ, and firmly adherent to the ventricular wall—which, in colour and consistence, and by its broken anfractuous free surface, closely corresponded to the lower part of the aortic clot. It was evidently too old to have been formed during the death-agony.

The left femoral artery was pervious down to the opening in the adductor. Just above this, a very large collateral branch passed off; and from this point downwards, the femoral and popliteal artery, and the three crural branches for some distance, were obstructed by a clot, for the most part recent. M. Broca supposes that, in the first place, a portion of the cardiac clot was broken off, and carried by the stream of blood to the bifurcation of the aorta, where it lodged, becoming the nucleus for the further deposit of a more recent clot above it. That the circulation of the limbs was sufficiently restored, after the first accident, by collateral channels. That then, possibly, some fragments, detached